DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/18/10

PRINTED: 08/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445238	A. BUILDING _____ B. WING _____	08/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF TULLAHOMA	1715 N JACKSON ST TULLAHOMA, TN 37388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey and Complaint investigation #25064, #26160, and #26245. were completed at Life Care Center of Tullahoma on August 2 - 4, 2010. No deficiencies were cited in relation to complaint #26160 and #26245 under 42 CFR Part 482.13, Requirements for Long Term Care. Deficiencies were cited on Complaint investigation #25064.	F 000	Preparation and/or execution of this plan of correction by the provider does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The allegation of compliance is prepared and/or executed solely because it is required by the provision of Federal and State Law.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure dignity was maintained for one resident (#15) of twenty-six residents reviewed. The findings included: Resident #15 was admitted to the facility on July 26, 2010, with diagnoses including Aftercare of Surgery, Rehabilitation, Chronic Obstructive Pulmonary Disease, and Peripheral Vascular Disease. Observation during the initial tour on August 2, 2010, at 9:00 a.m., in the resident's room, revealed a urinal sitting on the night stand ¾ full of urine. Interview with the resident at the time of the observation revealed the urinal filled with urine	F 241	1) It is the practice of Life Care Center of Tullahoma to promote care and treatment for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Resident #15's urinal was emptied and cleaned on 08/02/2010. 2) Unit Managers checked rooms to ensure no urinals were un-emptied on night stands on 08/02/2010, 08/03/2010 and 08/04/2010. 3) The Director of Nursing Inserviced Nursing staff regarding emptying and cleaning of urinals on 08/11/2010 and 08/17/2010. Unit Managers will perform room audits weekly for 12 weeks to ensure urinals are being emptied and cleaned timely and will report findings to the DON. 4) Director of Nursing or Unit Manager will report occurrence of and results of audits to the interdisciplinary quality improvement committee for review and possible intervention.	08/20/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ken Cole
TITLE: Executive Director
(X6) DATE: 08/18/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 had been sitting on the night stand "all night." Continued interview and observation revealed the resident ate meals in the room using the over bed table, and had completed eating breakfast. Interview with the resident on August 4, 2010, at 7:10 a.m., in the resident's room, revealed the resident disliked the urinal filled with urine sitting on the night stand while eating meals. Interview with LPN #2 (Licensed Practical Nurse) on August 2, 2010, at 9:00 a.m., in the hallway, confirmed the urinal was to be emptied prior to having the breakfast tray served. Interview with the Director of Nursing (DON) on August 4, 2010, at 8:15 a.m., in the DON's office, confirmed the urinal was to be emptied prior to meal tray setup, and confirmed the urinal was not to be left sitting all night without being emptied.	F 241		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to apply a splint for one resident (#8) of twenty-six residents reviewed.	F 318	1) It is the practice of Life Care Center of Tullahoma to ensure residents with limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease of range of motion. Resident #8's record was reviewed, a physician's order written and the palm guard was applied on 08/02/10. 2) Unit Managers reviewed rehab recommendations and checked patients to ensure all residents had appropriate adaptive equipment on 08/02/2010, 08/03/2010 and 08/04/2010.	08/20/10

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F 318	Continued From page 2 The findings included: Resident #8 was admitted to the facility on September 18, 2008, with diagnoses including Cerebrovascular Accident, Aphasia, Dysphagia, Right Hemiplegia, Congestive Heart Failure, Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes, and Atrial Fibrillation. Medical record review of the Minimum Data Set (MDS) dated July 9, 2010, revealed the resident had short and long term memory deficits, moderately impaired cognitive skills, and had no loss in range of motion. Medical record review of a Rehabilitation Services Multidisciplinary Screening Tool dated June 24, 2010, revealed "...Resident holding (R) (right) hand in guarded position but able to actively open hand. Palm mildly reddened, palm guard ordered to be worn daily with the exception of skin care..." Observation on August 2, 2010, at 9:10 a.m., revealed the resident lying on the bed with the right hand in a fisted position, without a splint/palm guard in place. Observation on August 2, 2010, at 9:44 a.m., with the Director of Nursing and Certified Nursing Assistant (CNA) #2, revealed the resident lying on the bed with the right hand in a fisted position, without a palm guard in place. Continued observation revealed CNA #2 fully extended the fingers of the resident's right hand revealing a reddened palm, without skin breakdown. Observation on August 2, 2010, at 12:20 p.m., revealed the resident in a geri chair without a palm guard applied to the right hand.	F 318	3) The Director of Nursing Inserviced Rehab and Nursing staff regarding communication and application of adaptive equipment on 08/12/2010. Director of Nursing Inserviced use of adaptive equipment on 08/17/2010. Unit Managers will perform room audits weekly for 12 weeks to ensure adaptive equipment is in place and will report findings to the DON. 4) Director of Nursing or Unit Manager will report occurrence of and results of audits to the interdisciplinary quality improvement committee for review and possible intervention.	

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F 318	Continued From page 3 Medical record review of the Care Plan dated July 16, 2010, revealed the resident had right hemiparesis, however, no intervention was noted to address the resident's need for a palm guard to the right hand. Interview on August 2, 2010, at 2:05 p.m., with the Occupational Therapist, in the conference room, revealed the resident required the palm guard to prevent contracture development and to promote skin integrity. Observation and interview on August 2, 2010, at 2:25 p.m., with Licensed Practical Nurse (LPN) #1, revealed the resident lying on the bed with the right hand in a fisted position and confirmed the palm guard was not in place. Interview on August 2, 2010, at 2:30 p.m., with LPN #2, in the conference room, confirmed the facility had failed to revise the care plan to include the resident's need for the palm guard.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure	F 323	**1) It is the practice of Life Care Center of Tullahoma to ensure that each resident remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident #8's C.N.A. and nurse were inserviced regarding transfer assistance on 02/02/2010 (after the 02/01/2010 fall). Resident #13's body alarm was clipped to clothing on 08/02/2010. Resident #12's alarming bed mat was attached to alarm box on 08/02/2010.**	08/20/10

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F 323	Continued From page 4 adequate supervision for one resident (#8), and failed to ensure safety devices were in place or functional for five residents (#13, #12, #17, #1, and #6) of twenty-six residents reviewed. The findings included: Resident #8 was admitted to the facility on September 18, 2008, with diagnoses including Cerebrovascular Accident, Aphasia, Dysphagia, Right Hemiplegia, Congestive Heart Failure, Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes, and Atrial Fibrillation. Medical record review of the Minimum Data Sets (MDS) dated November 8, 2009, revealed the resident had short and long term memory deficits, moderately impaired cognitive skills, was totally dependent for transfers, did not walk, and had fallen in the past 31-180 days. Medical record review of the Fall Risk Assessments dated November 11, 2009, and February 1, 2010, revealed the resident was at risk for falls. Medical record review of the Care Plan dated November 5, 2009, revealed "Potential for falls r/t (related to) CVA (Cerebrovascular Accident) with right hemiparesis and poor safety awareness..." Medical record review of the nursing notes dated February 1, 2010, at 6:15 a.m., revealed "...was called to room by CNA (Certified Nursing Assistant). Entered room et (and) noted pt (patient) laying on floor mat beside bed on (R) side. CNA states '...slid off the bed when I walked to the door to yell for help.' Assessed pt,	F 323	Resident #17's body alarm was attached on 08/04/2010. Resident #1's care plan and physician orders were reveiwed and his body alarm found to be working on 08/03/2010. Resident #6's care plan and physician orders were reviewed and her body alarm was found to be working on 08/03/2010. 2) Director of Nursing and Unit Managers reviewed Care Plans, Physician Orders, Assistive Devices' and fall records for all current resident's on 08/03/2010 and 08/04/2010 to ensure correct. Ineffective devices were discontinued. 3) The Director of Nursing inserviced Rehab, Unit Managers and MDS Staff regarding falls management program on 08/03/2010. Director of Nursing inserviced Nursing staff regarding falls management program on 08/03/2010 and 08/17/2010. Nurses will check monitoring devices each shift for eight weeks. Unit Managers will perform record and room audits weekly for 12 weeks to ensure adequate documentation and that monitoring equipment is in place and will report findings to the DON. 4) Director of Nursing or Unit Manager will report occurrence of and results of audits to the interdisciplinary quality improvement committee for review and possible intervention.	

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F 323	Continued From page 5 no s/s (signs/symptoms) injury. Skin intact. ROM (range of motion) WNL's (within normal limits) for this pt..." Medical record review of a nursing note dated February 1, 2010, at 2:15 p.m., revealed "...Redness & bruising noted to (R) cheek, N.O. (new order) rec'd (received) as follows: x-ray (R) cheek..." Medical record review of an x-ray report of the facial bones dated February 1, 2010, revealed "...Findings: Bone mineralization: Normal. Fractures: None. Paranasal sinuses: Clear. Impression: Normal Examination." Interview on August 2, 2010, at 3:00 p.m., with the Director of Nursing, in the conference room, confirmed the resident had poor safety awareness and was dependent for transfers at the time of the fall on February 1, 2010. Continued interview confirmed the resident was left unattended, sitting on the side of the bed, at the time of the fall. Resident #13 was admitted to the facility on July 1, 2005, with diagnoses including Congestive Heart Failure, Alzheimer's Disease, Syncope, and Osteoporosis. Medical record review of the MDS (minimum data set) dated May 9, 2010, revealed the resident had short term memory problems, was totally dependent for transfers, required extensive assistance with ambulation, and had not fallen in the past 180 days. Medical record review of a Fall Risk Evaluation dated May 13, 2010, revealed the resident was at risk for falls.	F 323		

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F 323	Continued From page 6 Medical record review of the July 2010, physician's recapitulation orders revealed "...Body alarm while up in wheelchair and in bed..." Medical record review of the Care Plan dated May 17, 2010, revealed "...Potential for falls r/t (related to) hx (history) falls...osteoporosis, generalized weakness and difficulty walking..." Medical record review of the Care Plan revealed no intervention to address the resident's need for the body alarm. Observation on August 2, 2010, at 9:28 a.m., revealed the resident sitting in a wheelchair, in the resident's room. Observation revealed the body alarm was clipped to a blanket around the resident's shoulder, and not attached to the resident's clothing. Observation and interview, on August 2, 2010, at 9:40 a.m., with the Director of Nursing (DON) revealed the resident sitting in the wheelchair and confirmed the body alarm was not attached to the resident. Interview on August 3, 2010, at 8:05 a.m., with the Director of Nursing, in the lobby, confirmed the facility had failed to revise the care plan to include the resident's need for the body alarm. Resident #12 was admitted to the facility on December 19, 2007, with diagnoses including Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and History of Lung Cancer. Medical record review of the MDS (minimum data set) dated July 18, 2010, revealed the resident had short term memory deficits, required extensive assistance with transfers and ambulation, and had fallen in the past 31-180	F 323		

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F 323	Continued From page 7 days. Medical record review of a Fall Risk Assessment dated July 26, 2010, revealed the resident was at risk for falls. Medical record review of the Care Plan dated July 26, 2010, revealed "...Potential for injury...alarming bed mat..." Observation on August 2, 2010, at 9:58 a.m., revealed the resident lying on the bed with an alarming bed mat under the resident. Continued observation revealed the cord to the alarming bed mat was not attached to the alarm box. Observation and interview, on August 2, 2010, at 10:01 a.m., with the Director of Nursing, revealed the resident lying on the bed and confirmed the alarming bed mat was not connected to the alarm box. Resident #17 was admitted to the facility on October 24, 2008, with diagnoses including Rheumatoid Arthritis, Cirrhosis, and Hypertension. Medical record review of a Fall Risk Assessment dated June 19, 2010, revealed the resident was at high risk for falls. Medical record review of the Minimum Data Set dated June 26, 2010, revealed the resident had fallen in the past 30 days. Medical record review of the Physician's Telephone Order dated, June 22, 2010, revealed "...Body Alarm..."	F 323		

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F 323	Continued From page 8 Observation on August 4, 2010, at 7:20 a.m., in the resident's room, revealed the resident lying on the bed without the body alarm in place. Observation and interview on August 4, 2010, at 7:25 a.m., with the Licensed Practical Nurse #2, confirmed the body alarm was not in place. Resident #1 was admitted to the facility on April 18, 2007, with diagnoses including Hypertension, Right Hemiplegia, Colostomy, Rehabilitation, and Dyphagia. Medical record review of the Minimum Data Set dated July 18, 2010, revealed the resident had short and long term memory problems, moderately impaired decision making skills, was nonverbal, required assistance for transfers, was non ambulatory, and had fallen in the past 31-180 days. Medical record review of a Fall Risk Assessment dated February 13, 2010 revealed the resident was at risk for falls. Medical record review of the Care Plan updated March 5, 2010, revealed "Potential for falls r/t (related to) meds, weakness, difficulty in walking, abnormality of galt...use alarming bed mat." Review of the facility's investigation revealed the resident had a fall on February 13, 2010, and March 15, 2010. Continued review of the facility investigation for the February and March falls revealed the alarming bed mat was in place but not sounding.	F 323		

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Interview with the DON in the DON's office, on August 3, 2010, at 4:15 p.m., confirmed the alarming bed mats were in place on February 13, 2010, and March 15, 2010, but were not sounding.

Resident #6 was admitted to the facility on July 11, 2009, with diagnoses including Mental Disorder, Congestive Heart Failure, Atrial Fibrillation, Bone and Cartilage Disease, Difficulty Walking, Dementia, Alzheimer's Disease, History of Fall, Muscle Weakness, Osteoporosis, and Depression.

Medical record review of the Fall Risk Assessments dated July 26, 2009 through January 18, 2010, revealed the resident had a history of falls and was at high risk for falls.

Medical record review of the Care Plan dated July 18, 2009 through November 24, 2009, with updated approaches dated January 15, 2010, revealed a "Potential for falls r/t (related to) hx (history) falls...difficulty walking...and general weakness." Further medical record review of the care plan revealed approaches to apply a body alarm and had been revised on November 20, 2009, to include an alarming bed mat.

Medical record review of a nursing note dated January 18, 2010, at 5:15 a.m., revealed "At 1:30 AM heard resident yelling went into room. Resident sitting on gray mat by...bed. Resident sitting upright with knees bent. BLE (bilateral

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F 323	Continued From page 10 lower extremities) full ROM (range of motion). No c/o (complaint) pain...Alarming bed mat on not alarming..." Interview with the Director of Nursing (DON), on August 3, 2010, at 3:15 p.m., in the DON office, confirmed the resident had a history of falls and the alarming bed mat was not sounding on January 18, 2010. C/O #25064	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer recommendations, and interview, the facility failed to operate the dish machine at a minimum of 160 degrees Fahrenheit during the wash cycle. The findings included: Observation on August 2, 2010, at 9:05 a.m., revealed two members of the dietary staff loading dishes into and unloading dishes out of the dish machine in the dietary department. Further observation revealed the staff member unloading	F 371	1) It is the practice of Life Care Center of Tullahoma to store, prepare, distribute and serve food under sanitary conditions including operating the dish machine at a minimum of 160 degrees Fahrenheit during the wash cycle. Dietary staff stopped washing dishes until temperatures increased to the manufacturers recommended temperatures on 08/02/10. 2) Maintenance Department and Contracted dish machine service company worked on dish machine on 08/02/2010 to increase wash cycle temperatures. Environmental Services Director and Dietary Manager inserviced dietary staff regarding monitoring wash and rinse cycle temperatures and what to do if they dropped on 08/02/2010. 3) Assistant Dietary Manager inservice dietary staff regarding wash and rinse cycle temperature requirements and what to do if temperatures dropped on	08/20/10

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	445238	A. BUILDING _____ B. WING _____	08/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF TULLAHOMA	1715 N JACKSON ST TULLAHOMA, TN 37388

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F 371	Continued From page 11 the dishes and placing the dishes for storage in storage units for future use. Observation of eight consecutive cycles revealed the wash temperature ranged from 149 to 152 degrees Fahrenheit (F). Review of the dish machine manufacturer recommendations, posted onto the machine, revealed 160 degrees F was the minimum wash temperature. Interview with the Dietary Manager, present during the observation, on August 2, 2010, at 9:05 a.m., confirmed the wash temperature did not reach the manufacturer's recommended 160 degree F in eight consecutive cycles.	F 371	08/02/2010. Longer wash curtains were ordered for the dish machine on 08/02/2010. Dish washers will maintain daily temperature logs to ensure proper temperatures are maintained. Dietary Staff monitored dish washing machine temperatures every 15 minutes while washing for 4 days. Dish washing is stopped for 5 minutes or until it increases sufficiently if temperatures drop close to 160 degrees during wash cycle. Assistant Dietary Manager will review temperature logs daily for 2 weeks and weekly for 10 weeks to ensure proper temperatures are maintained. 4) Dietary Manager or Assistant Dietary Manager will report occurrence of and results of temperature log reviews to the interdisciplinary quality improvement committee for review and possible intervention.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441 F441	1) It is the practice of Life Care Center of Tullahoma to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Certified Nursing Assistants #1, #3 and #4 were inserviced regarding proper handwashing on 08/04/2010. 2) Unit Managers made room rounds to observe Certified Nursing Assistant hand washing technique on 08/02/2010,	08/20/10

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F 441	Continued From page 12 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility staff failed to wash the hands after providing incontinence care for two residents (#8, #7) of twenty-six residents reviewed. The findings included: Observation on August 2, 2010, at 1:45 p.m., revealed Certified Nursing Assistant (CNA) #1 providing incontinence care to resident #8. Observation revealed after providing incontinence care CNA #1 applied an oxygen cannula to the nares of the resident without changing the gloves or washing the hands. Interview on August 2, 2010, at 4:00 p.m., with the Director of Nursing, in the conference room, confirmed the gloves were to be removed and the hands washed after providing incontinence care, prior to applying an oxygen cannula, and	F 441	08/03/2010 and 08/04/2010. 3) The Director of Nursing inserviced Nursing staff regarding handwashing on 08/03/2010, 08/11/2010 and 08/17/2010. Unit Managers will perform audits weekly for 12 weeks to ensure proper handwashing is in place and will report findings to the DON. 4) Director of Nursing or Unit Manager will report occurrence of and results of audits to the interdisciplinary quality improvement committee for review and possible intervention.	

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F 441	Continued From page 13 confirmed proper hand hygiene was not completed. Resident #7 was admitted to the facility on May 25, 2010, with diagnoses including Rehabilitation, Hypertension, Hypothyroidism, and Personal History of Falls. Observation on August 2, 2010, at 3:55 p.m., in the resident's room, revealed two CNA's (Certified Nursing Assistant) performing perineal care wearing gloves. Continued observation revealed CNA #4 performed care to the front area, and CNA #3 performed care to the buttocks area. Continued observation revealed after the CNAs performed the direct care, CNA #4 opened the night stand drawer with the gloves worn to perform direct care and placed supplies in the drawer. Continued observation revealed CNA #3 and #4 adjusted the resident's clothes and bed linen without changing gloves. Further observation revealed CNA #3 adjusted the privacy curtain with the soiled gloves. Interview with both CNA's on August 2, 2010, at 4:05 p.m., in the hallway, confirmed gloves were not removed after providing direct care and prior to handling clothes, linen, and privacy curtain. Interview with the Director of Nursing (DON) on August 3, 2010, at 4:20 p.m., in the DON's office, confirmed the staff failed to remove gloves and disinfect hands after providing direct care.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514	Continued From page 14 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain an accurate medical record for one resident (#2) of twenty-six resident records reviewed. The findings included: Resident #2 was admitted to the facility on November 3, 2008, and readmitted on October 10, 2009, with diagnoses including Pressure Ulcer Stage IV, Generalized Pain, Gastrointestinal Hemorrhage, Osteoarthrosis, Anemia, Lumbago, and Osteoporosis. Medical record review of the July 2010, Physician Recapitulation Orders revealed "Roxanol 10 MG/tsp (milligrams per teaspoon): take one to two teaspoons per mouth every 3 - 4 hours as needed (PRN) for pain" had been initiated on March 2, 2010. Further medical record review revealed "...ALL PRN (as needed) pain meds (medications) given must be documented on Pain Flow Sheet" had been initiated on October 10,	F 514	**1) It is the practice of Life Care Center of Tullahoma to maintain an accurate medical record for each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. The Director of Nursing and Unit Manager reviewed the MAR, the Pain Flow Sheet and the Controlled Substance Records of Resident #2 on 08/04/2010 to ensure they reconciled.** **2) Director of Nursing and Unit Managers audited MAR's, Pain Flow Sheets and Controlled Substance Records to ensure they reconciled on 08/04/2010.** **3) The Director of Nursing inserviced Nursing staff regarding documentation and record reconciliation on 08/11/2010 and 08/17/2010. Unit Managers will perform audits weekly for 12 weeks to ensure MARS, Pain Flow Sheets and Controlled Substance Records reconcile and will report findings to the DON.** **4) Director of Nursing or Unit Manager will report occurrence of and results of audits to the interdisciplinary quality improvement committee for review and possible intervention.**	08/20/10

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F 514	Continued From page 15 2009. Medical record review of the Medication Administration Record (MAR) for June 2010, revealed Roxanol was administered one time only on "June 1, 2, 4, 6, 8, 10, 11, 13, 14, 19..." Medical record review of the June 2010, Pain Flow Sheet revealed Roxanol was provided "June 2, 3, 4, 6, 8, 9, 10, 11, 14 (two administrations), 16, 18, 19..." Medcial record review of the Controlled Substance Record for June 2010, revealed Roxanol was administered on June 2, 3, 4, 6, 8, 9, 10, 11, 13, 14 (two administrations), 16, 18, 19..." Interview, with the Director of Nursing, on August 4, 2010, at 10:20 a.m., at the West nursing station, confirmed the MAR, Pain Flow Sheet, and the Controlled Substance Record, for Roxanol, in June 2010, did not reconcile and the medical record was not accurate.	F 514		